Multi-Agency Guidance on Safeguarding in Relation to Concealed or Denied Pregnancy v.5

Policy Version History

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1. Introduction

1.1. This policy and procedure is for anyone who may encounter a woman or girl who conceals the fact that she is pregnant or where a professional has a suspicion that a pregnancy is being concealed or denied. This policy and procedure should be read in conjunction with Suffolk Local Safeguarding Children Board multi-agency procedures for safeguarding children.

1.2. The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and well-being of the foetus (unborn child) and the mother. While concealment and denial, by their very nature, limit the scope of professional help better outcomes can be achieved by co-ordinating an effective inter-agency approach. This approach begins when a concealment or denial of pregnancy is suspected or in some cases when the fact of the pregnancy (or birth) has been established. This will also apply to future pregnancies where it is known or suspected that a previous pregnancy was concealed.

2. Definition

2.1. A concealed pregnancy is when a woman or girl knows she is pregnant but does not tell any health professional; **or** when she tells another professional but conceals the fact that she is not accessing antenatal care; **or** when a pregnant woman or girl tells another person/s and they collude with her to conceal the fact that she is pregnant from all health agencies.

2.2. A denied pregnancy is when a woman or girl is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases, a woman or girl may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005).

2.3. For the purpose of this policy and procedure any reference to a woman or girl relates to a female of any age with child bearing capacity (including under 18's). A pregnancy will not be considered to be concealed or denied for the purpose of this procedure until it is confirmed to be at least 24 weeks; this is the point of viability. However, by the very nature of concealment or denial it is not possible for anyone suspecting a woman or girl is concealing or denying a pregnancy to be certain of the stage the pregnancy is at.

3. Evidence from Research and Serious Case Reviews

3.1. There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women or girls may have a variety of reasons for their behaviour.

3.2. Late commencement of antenatal care may be a feature of teenage pregnancy, for a variety of reasons. These include not fully understanding the consequences and complications of risk factors in pregnancy, poor motivation to keep appointments, concealment or denial of pregnancy. However, research does indicate that concealment appears to be reported equally across all ages; it is not just a teenage phenomenon. Professionals should be aware that concealment of pregnancy can occur at any age where the woman or girl is biologically able to conceive.

3.3. In some cases, the woman or girl may be truly unaware that she is pregnant until very late into the pregnancy. For example, a young woman or girl with a learning disability may not understand why her body is changing.

3.4. Denial may persist as a result of thinking that the problem will go away if it is ignored.

3.5. Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.

3.6. A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse or exploitation, either within or outside the family, due to her fear of the consequences of making a disclosure.

3.7. Some pregnant women, or their partners, who abuse drugs and/or alcohol may actively avoid seeking medical help during pregnancy for fear that the consequences of increased attention from statutory agencies can result in the removal of their child.

3.8. A woman or girl who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant.

3.9. There have been cases where the mother not only conceals the pregnancy and birth, but also the baby's body, should the baby die. Concealed birth (including concealed still birth) represents a criminal offence, though enquiries into these circumstances should be conducted sensitively and with due regard to the context in which this takes place.

3.10. A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.

3.11. In some religions and cultures, a pregnancy outside of marriage may have life threatening consequences for the woman or girl involved. In these instances, women or girls have been known to conceal their pregnancy or 'disappear' to avoid bringing shame to the family. In some local and national cases collusion between family or partners has occurred to facilitate and encourage concealment of the pregnancy from those outside of the family or wider culture/community.

3.12. Local Safeguarding Children Boards have conducted reviews of cases where concealment or denial of pregnancy has been identified as a factor in the death or serious injury of a child. According to the NSPCC there were two Serious Case Reviews undertaken last year (2014) in England where concealment of pregnancy was felt to be a significant factor. One of these tragic cases related to the death of an 11-month-old boy, as the result of a serious head injury and the other a serious head injury sustained by a 6-month-old baby. Learning included:

- The need for greater professional awareness of issues related to concealed pregnancies.
- The importance of investigation in cases of concealed pregnancy, including the psychological and psychiatric status of the parents.

3.13. Several studies (Earl, 2000; Friedman, 2005; Vallone, 2003) also highlight a well-established link between neonaticide – killing of a child by a parent in the first 24 hours following birth – and concealed pregnancy.

4. Implications of a Concealed or Denied Pregnancy

4.1. The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother's intention.

4.2. Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given; such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy e.g. some epilepsy medication.

4.3. Underlying medical conditions and obstetric problems will not be revealed if antenatal care is not sought. An unassisted delivery can be very dangerous for both mother and baby, due to complications that can occur during labour and the delivery. A midwife should be present at birth, whether in hospital or if giving birth at home.

4.4. 'Freebirthing', or unassisted birthing, is growing in popularity in the United States and has been reported in the UK. Freebirth is where a woman or girl chooses to give birth without the assistance of health professionals. In some instances, the women were reported to engage in antenatal care, but others chose to avoid any professional involvement whatsoever.

4.5. Good Practice in Antenatal Care

Midwives and GP's should care for woman or girl with an uncomplicated pregnancy, providing continuous care throughout. Obstetricians and specialist teams should be brought in where necessary.

- ✓ In the first contact with a health professional a woman or girl should be given information on folic acid supplements; food hygiene and avoiding food-acquired infections; lifestyle choices such as smoking cessation or drug use; and the risks and benefits of antenatal screening.

- ✓ The booking appointment with a midwife ideally should be around 10 weeks. This appointment should help the woman or girl plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The woman or girl should be given advice on nutritional supplements and benefits.

- ✓ Give information that is easily understood by all women and girls, including those with additional needs, learning difficulties or where English is not their first language using interpreters and translated materials as necessary. Ensure the information is clear, consistent and backed up by current evidence.

- ✓ Remember to give a woman or girl enough time to make decisions and respect her decisions even if they are contrary to your own views.

- ✓ The woman or girl should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence.

Adapted from Antenatal care: Routine care for the healthy pregnant woman, NICE (2008)

4.6. When a woman or girl presents late for booking (after 24 weeks of pregnancy), the pregnancy need to be closely monitored to assess future engagement with health professionals, particularly midwives and whether or not referral to another agency is indicated.

4.7. Research undertaken in other authorities has found that concealment appears to be reported equally across all ages. It is not just a teenage phenomenon.

4.8. Nirmal et al (2006) identified a preponderance of concealed pregnancies during the winter months.

4.9. Previous concealed pregnancy may also be regarded as an important indicator in predicting risk of a future pregnancy being concealed with a harmful outcome for the child.

4.10. Research also identified the following indicators:

- Previous termination, thoughts of termination and/or unwanted pregnancy.
- Loss of a previous child (i.e. adoption, removal under Care Proceedings).
- General fear of being separated from the child.

4.11. There could be a number of reasons why women or girls fear that they will be separated from their child. Research evidence suggests that substance-misusing women or girls may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their child.

It may be important to consider the role of collusion within the family. In some national and local cases, the family appeared to encourage the concealment and the mother's own family were aware of the situation, and the pregnant daughter was allowed to develop high levels of privacy in the home.

4.12. An implication of concealed or denied pregnancy could be a lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth.

It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. In a case of a denied pregnancy the effects of going into labour and giving birth can be traumatic.

4.13. Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently.

4.14. There may also be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; or because revealing the identity of the child's father may have consequences for the parents and the child.

5. Where Suspicion of Concealment or Denial of Pregnancy Arises

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5.1. This section outlines actions to be taken when a concealed or denied pregnancy is suspected (see definition in section 2).

5.2. If a pregnancy is suspected of being concealed or denied, the woman or girl should be strongly encouraged to go to her GP to access ante-natal care.

The GP practice will help a woman or girl register with midwifery services for ultrasound scanning and advice about pregnancy and birth.

5.3. Professionals must balance the need to conserve confidentiality and the potential concern for the unborn child and the mother's health and well-being.

Where any professional has concerns about concealment or denial of pregnancy then they should contact other agencies known to have involvement with the woman or girl so that a fuller assessment of the available information and observations can be made.

5.4. Where there is a strong suspicion that there is a concealed or denied pregnancy then it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child will override the mother's right to confidentiality.

5.5. **A referral should be made to Suffolk Multi Agency Safeguarding Hub (MASH) via Customer First on 0808 800 4005 about the unborn child.**

Telephone referrals should be followed up within 24hrs with a Multi-Agency Referral Form (MARF). MARF Referral Form

5.6. **If the woman is aged less than 18 years then consideration will be given to whether she is a vulnerable young person. If she is less than 16 years then a criminal offence may have been committed and this may need to be investigated.**

5.7. The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn child or newborn baby. The reasons will not be known until there has been a systematic multi-agency assessment.

If there is a denial of pregnancy, then consideration must be given at the earliest opportunity to a referral which will enable the woman or girl to access appropriate mental health services for an assessment.

Norfolk and Suffolk Foundation Trust (NSFT) Access and Assessment Team undertake assessment and signposting in relation to routine, urgent and emergency referrals for mental health input.

Tel: 0300 123 1334 or Fax 0300 123 1335.

Referrals should be followed up in writing to:

NSFT Access and Assessment Team Suffolk
Mariner House
Handford Road
Ipswich IP1 2GA

6. Legal Considerations

6.1. UK law does not legislate for the rights of unborn children and therefore a foetus is not a legal entity and has no separate rights from its mother. This should not prevent plans for the protection of the child being made and put into place to safeguard the baby from harm both during pregnancy and after the birth.

6.2. In the case of F (in utero) 1988 the Court of Appeal was asked to make a foetus a ward of court by a Local Authority concerned for the welfare of the child. The pregnant woman or girl's previous child was in foster care and she was described as having a mental disturbance, nomadic lifestyle and occasional drug use. The Court was entirely opposed to the proposed action, with one judge stating that the purpose was to control the woman or girl's actions to protect the unborn child to the extent that she would be ordered to stop smoking, imbibing alcohol and refraining from all hazardous activity (Royal College of Obstetrics and Gynaecology, 2006).

6.3. In certain instances legal action may be available to protect the health of a pregnant woman or girl, and therefore the unborn child, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that a person must be assumed to have capacity unless it is proven that she does not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that a pregnant woman or girl denying her pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case.

6.4. There are no legal means for a Local Authority to assume parental responsibility over an unborn child. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn child or give the local authority any power to override the wishes of a pregnant young woman or girl in relation to medical help.

7. When a Concealed or Denied Pregnancy is Revealed

7.1. This section outlines actions to be taken when a concealed or denied pregnancy is revealed. Midwifery services will be the primary agency involved with a woman or girl after the concealment is revealed, late in pregnancy or at the time of birth.

However, it could be one of many agencies or individuals that a woman or girl discloses to or in whose presence the labour commences. It is vital that all information about the concealment or denial is recorded and shared with relevant agencies to ensure the significance is not lost and risks can be fully assessed and managed.

7.2. When a pregnancy is revealed the key question is 'why has this pregnancy been denied or concealed'? The circumstances in each case need to be explored fully with the woman or girl and appropriate support and guidance given to her.

When a pregnancy is concealed or denied, a referral must be made by sending a Multi-Agency Referral Form Multi-Agency Referral Form (MARF) to Customer First at customer.first@suffolk.gcsx.gov.uk

Telephone referrals will be accepted by Customer First on 0808 800 4005 only when the baby is at immediate risk of significant harm. Telephoned referrals must be followed up within 24hrs with a Multi-Agency Referral Form (MARF).

Customer First and MASH will respond swiftly when concerns are raised about a concealed or denied pregnancy, especially when the baby is about to be or has already been born. MASH will always consult with the Named Midwife (or, if not available, the Senior Midwife) to ensure that any hospital discharge of the baby is planned and safe.

MASH will gather and analyse additional information from relevant partner agencies (including the Named Midwife or Senior Midwife) and from the parents, where this is safe and possible.

MASH will reach a judgement about whether a social work/pre-birth assessment is required (either under s.47 or s.17 of the Children Act 1989). MASH will liaise closely with the Named Midwife (Senior Midwife). Where a strategy threshold discussion is required, MASH will invite the Named Midwife to participate in this.

An assessment by children's social care is likely to be required *unless* no other risk indicators have been identified and the family is now making appropriate and timely preparations for the baby.

If assessments confirm that the child/unborn baby is likely to suffer significant harm, an initial/pre-birth child protection conference may need to be convened to help the family manage and reduce risks.

7.3. If any professional considers that their concerns are not being responded to appropriately, the LSCB Escalation Policy should be used and support sought from a Named Professional for Safeguarding Children within their organisation.

7.4 Before discharging the mother and baby home, an agreement should be reached between the Named Midwife and MASH Manager. If the process hasn't been completed within the MASH working hours or if the Named Midwife or hospital has concerns, the Named Midwife should call the EDS service or re-refer to Customer First.

7.5 If concerns relate to a member of staff they must be discussed with a Local Authority Designated Officer (LADO). The LADO can be contacted via email on LADOCentral@suffolk.gcsx.gov.uk or the central telephone number 0300 123 2044.

See the LSCB Policy 'Arrangements for Handling Allegations of Abuse Against People who work with Children or Those Who are in a Position of Trust' and the LADO Referral Form.

8. Educational Settings

8.1. In many instances staff in educational settings may be the professionals who know a young woman or girl best. There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

- Increased weight or attempts to lose weight;
- Wearing uncharacteristically baggy clothing;
- Concerns expressed by friends;
- Repeated rumours around school or college;
- Uncharacteristically withdrawn or moody behaviour.

8.2. Staff working in educational settings should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive problem. The professional suspecting a pregnancy, should make every to encourage the young woman or girl to obtain medical advice. However, where they still face total denial or non-engagement further action should be taken. It may be appropriate to involve the assistance of the Designated Person for Child Protection in addressing these concerns.

8.3. Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained.

8.4. Education staff may often feel the matter can be resolved through discussion with the parent of the young woman or girl. However, this will need to be a matter of professional judgement and will be clearly dependant on individual circumstances, including relationships with parents.

It may be felt that the young woman or girl will not admit to her pregnancy because she has genuine fear about her parent's reaction, or there may be other aspects about the home circumstances that give rise to concern. If this is the case then a referral to Suffolk MASH should be made without speaking to the parents first.

When a pregnancy is concealed or denied, a referral must be made to Suffolk MASH. by sending a Multi-Agency Referral Form (MARF) to Customer First at customer.first@suffolk.gcsx.gov.uk

8.5. If education staff do engage with parents they need to bear in mind the possibility of parents' collusion with the concealment. Whatever action is taken, whether informing the parents or involving another agency, the young woman or girl should be appropriately informed, unless there is a genuine concern that in so doing she may attempt to harm herself or the unborn baby.

8.6. If there is a lack of progress in resolving the matter in the setting or escalating concerns that a young woman or girl may be concealing or denying she is pregnant there must be a referral to Suffolk MASH. (see above)

Where there are significant concerns regarding the girl's family background or home circumstances, such as a history of abuse or neglect, a referral should be made immediately. As with any referral to Suffolk MASH, the parents and young woman or girl should be informed, unless in doing so there could be significant concern for her welfare or that of her unborn child.

9. Health Professionals

9.1. NHS England have responsibility for commissioning provision of Primary Care. All acute and community health services in hospital and community settings are commissioned by local Clinical Commissioning Groups. The local commissioners of health services are responsible for ensuring all its providers fulfil their statutory responsibilities for safeguarding children.

9.2. The health professionals whom may be involved include:

- Health Visitors
- School nurses
- General Practitioners and Practice nurses
- Midwifes and Obstetricians/Gynaecologists
- Mental Health Nurses
- Drug and Alcohol workers
- Learning Disability workers
- Psychologists and Psychiatrists

9.3. If a health professional suspects or identifies a concealed or denied pregnancy and there are significant concerns for the welfare of the unborn baby they must refer to Suffolk MASH and inform all the health professionals, including the General Practitioner, involved in the care of the woman or girl. If a Freebirth or unassisted birth becomes known to maternity services at the time of delivery, it is treated the same as a concealed pregnancy and will trigger a referral to MASH.

9.4. All health professionals should give consideration to the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy. Accident and Emergency staff or those in Radiology departments need to routinely ask women of child bearing age whether they might be pregnant. If suspicions are raised that a pregnancy may be being concealed, this should be recorded and an appropriate note made to the referring physician or GP for follow up with the patient.

9.5. Health professionals who provide help and support to promote children's or women's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman or girl may be concealing or denying a pregnancy.

10. Midwives and Midwifery Services

10.1. If an appointment is for antenatal care is made late (beyond 24 weeks) the reason for this must be explored. Midwives and Obstetricians should consider whether a mental health referral is indicated. If an exploration of the circumstances suggests a cause for concern for the welfare of the unborn baby then a referral should be made to Suffolk MASH. The woman or girl should be informed that the referral has been made, the only exception being if there are significant concerns for her safety or that of the unborn child.

10.2. Hospital acute trusts will follow their own clinical policies in relation to providing care to the woman or girl.

10.3. If a woman or girl arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, then an urgent referral must be made to Suffolk MASH.

10.4. If the baby has been harmed in any way or there is a suspicion of harm, or the child is abandoned by the mother, then the Police must be informed immediately and a referral made to Suffolk MASH.

10.5. Midwives should ensure information regarding the concealed pregnancy is placed on the child's, as well as the mother's health records.

Following an unassisted delivery or a concealed/denied pregnancy midwives need to be alert to the level of engagement shown by the mother, and her partner/extended family if observed, and of receptiveness to future contact with health professionals.

In addition, midwives must be observant of the level of attachment behaviour demonstrated in the early postpartum period.

10.6. In cases where there has been concealment and denial of pregnancy and there are concerns about the woman's mental health, an assessment by NSFT Access and Assessment should be completed. In addition, the baby should not be discharged until there has been liaison between the MASH and the Named Midwife or Senior Midwife, and/or a multi-agency strategy meeting has been held and relevant assessments undertaken. A discharge summary from maternity services to primary care must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

11. Children and Young People's Services

11.1. Suffolk MASH may receive a referral from any source which suggests a pregnancy is being concealed or denied. MASH will reach a judgement about whether a social work/pre-birth assessment is required (either under s.47 or s.17 of the Children Act 1989). MASH will liaise closely with the Named Midwife (or Senior Midwife). Where a strategy threshold discussion is required, MASH will invite the Named Midwife to participate in this.

An assessment by children's social care is likely to be required *unless* no other risk indicators have been identified and the family is now making appropriate and timely preparations for the baby.

11.2. Where the expectant mother is under the age of 18 initial approaches should be made confidentially to the young woman to discuss concerns regarding the potential concealed pregnancy and unborn child. She should be provided with the opportunity to satisfy social workers that she is not pregnant, by undertaking appropriate medical examination or investigation, or to make realistic plans for the baby, including informing her parents where appropriate.

11.3. In the event that the young woman or girl refuses to engage in constructive discussion, and where parental involvement is considered appropriate to address risk, the parent/main carer should be informed and plans made wherever possible to ensure the unborn baby's welfare. Potential risks to the unborn child or to the health of the young woman or girl would outweigh the young woman or girl's right to confidentiality, if there was significant evidence that she was pregnant. There may be significant reasons why a young woman or girl may be concealing a pregnancy from her family and a social worker may need to consider speaking to her without her parent's knowledge in the first instance.

11.4. If the young woman or girl refuses to engage in constructive discussion then the social worker will need to inform her parents or carers and continue to assess the situation with a focus on the needs and welfare of the unborn baby as well as those of the young woman or girl, who should also be considered a vulnerable young person. In this situation professionals will have very clear reasons for suspecting pregnancy in the face of continuing denial or concealment and such a situation will require very sensitive handling.

11.5. Regardless of the age of the woman where there are additional concerns (to the suspected concealed or denied pregnancy) such as a lack of engagement, possibility of sexual abuse, or substance misuse; then a multi-agency strategy threshold discussion/meeting should be held to determine whether a Section 47 child protection enquiry will be undertaken. Where a woman under age 18 is suspected of being pregnant then professionals must not lose sight of the fact that she is also a vulnerable young person and may require safeguarding in her own right.

11.6. If a woman or girl has arrived at hospital either in labour (when a pregnancy has been concealed or denied) or following an unassisted birth, the need for a strategy threshold discussion and s.47 enquiry or s.17 social work assessment must be carefully considered (see paragraphs 7.2 – 7.4).

11.7. Where a baby has been harmed, - or abandoned then a joint Section 47 enquiry must be undertaken in partnership with the Police. Where a baby has died, SUDIC (Sudden or Unexplained Death in Infancy or Childhood) the Suffolk LSCB SUDIC Protocol must be followed. The welfare and safety of any surviving siblings must be considered.

11.8. Any referral received by Suffolk MASH in relation to a baby born following a concealed or denied pregnancy, or where a mother and baby have attended hospital following an unassisted delivery will involve a dialogue with both the hospital and, where possible and safe, the parent/s to ensure that shared decision making takes place. Steps may be taken to prevent the baby being discharged from hospital until a multi-agency strategy meeting has been held and a plan for discharge agreed. This would ordinarily be done by voluntary agreement with the mother, although clearly circumstances may arise when it may be appropriate for the Local Authority to seek an Emergency Protection Order or, where any delay would risk significant and immediate harm to the baby, to seek Police Powers of Protection to prevent the child from being removed from the hospital.

11.9. In undertaking an assessment, the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child. These factors along with the other elements of the assessment will be key in determining risk.

11.10. Accessing psychological services in concealment and denial of pregnancy may be appropriate and consideration should be given to referring a woman or girl for psychological assessment. There could be a number of issues for the woman or girl which would benefit from psychological intervention. A psychiatric assessment might be required in some circumstances, such as where it is thought she poses a risk to herself or others or in cases where a pregnancy is denied.

11.11. The pathway for psychological or psychiatric assessment, either before or after pregnancy is the same. A referral should be made to the NSFT Access and Assessment Team (see page 6) and the referral letter copied to the woman or girl's GP. The referral should make clear any issues of concern for the woman or girl's mental health and issues of capacity.

12. Police

12.1. The Police, as a key agency within Suffolk MASH, will be part of any multi-agency strategy threshold discussion and decision making process, to consider the circumstances of a referral and decide whether a s.47 joint Child Protection enquiry should be carried out.

12.2. Factors to consider will be the age of the woman or girl who is suspected or known to be pregnant, and the circumstances in which she is living to consider whether she is a victim or potential victim of criminal offences. In all cases where a child has been harmed, abandoned or died, Police and Children's Services will work together to investigate the circumstances. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency. The welfare and safety of any surviving siblings must be considered.

13. Other Suffolk LSCB Partner Agencies (including the Voluntary Sector)

13.1 All professionals or volunteers in statutory or voluntary agencies who provide services to women of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises. All referrals will be made to Customer First initially as a referral on an unborn child. Where the expectant mother is under 18 years of age she will also be considered as a vulnerable young person and assessed accordingly.

Referrals must be made by sending a Multi-Agency Referral Form (MARF) to Customer First at customer.first@suffolk.gcsx.gov.uk

Telephone referrals will be accepted by Customer First on 0808 800 4005 only when the baby is at immediate risk of significant harm. Telephone referrals must be followed up within 24hrs with a Multi-Agency Referral Form (MARF)

14. Communication and Ongoing Care of Mother and Baby

14.1 By the time the mother is discharged home from hospital with her baby, the professionals involved in their care must have satisfied themselves that they have an adequate and credible understanding of why the pregnancy was concealed and that the baby's safe care is assured. Please also see Section 7.5.

14.2 This should include an understanding of whether or not the mother is suffering from any form of mental disorder, in addition to the ongoing monitoring and care packages which will be in place once mother is at home.

14.3 Following transfer home, the mother and baby will be supported initially by the midwifery service. Close liaison and communication with the Health Visitor will be established, prior to discharge from the maternity service between 10-14 days post-delivery.

14.4 If an assessment is undertaken by Children & Young People's Services and concerns are confirmed, the baby's family will be supported to develop a Safety Plan though a Family Network Meeting. The baby (and mother if under 18) may require a multi-agency Child in Need Plan or Child Protection Plan and agencies will work together to support the family.

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Key Amendments, Updates and Stakeholders

- The addition of SUDIC at Section 11.
- Tightening of the MASH procedures and MASH role at Section 7.
- Section 14 - addition of before discharge, an agreement between the Named Midwife and MASH Manager.
- Family supported on discharge if an assessment has been undertaken, to develop a Family Network Meeting (FNM).
- 'Free birthers', known to maternity services, treated the same as Concealed Pregnancy and send referral to MASH.
- Consistency in the use of the named Midwife or Senior Midwife.

In consultation with:

- Multi-agency Safeguarding Hub (MASH)
- David Jacobs, Head of Service for Children's Social Care, Suffolk County Council.
- Head of Safeguarding and Reviewer Officer Service, Suffolk County Council.
- Cindie Dunkling, Designated Nurse Safeguarding Children, Ipswich and East Suffolk CCG and West Suffolk CCG.
- Named Midwives:
    - Ipswich Hospital – Kerry Hoskings
    - West Suffolk Hospital – Hayley Rowan
    - James Paget Hospital – Daniela Casasso